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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07767

## 7762 CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
OR TOWN <u>Rural Grantsville</u>		LENGTH OF STAY (in this place) <u>35 yrs</u>		TOWN <u>Rural Grantsville</u>		STREET ADDRESS (If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>ANNIE</u> (Middle) <u>MARIE</u> (Last) <u>BAUM</u>				(Month) <u>Aug.</u> (Day) <u>19</u> (Year) <u>1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Jan. 11, 1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>housewife</u>		<u>own home</u>		<u>Frostburg, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Melchoff Youngerman</u>				<u>Anna Martha Rase</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Harold Baum, Grantsville, Md. RD.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>Cerebral Thrombosis</u>						<u>2 weeks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>						<u>15 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic secondary anemia</u>						<u>20 years</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
<u>none</u>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>6/25</u> , 19 <u>55</u> , to <u>8/19</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/18</u> , 19 <u>55</u> , and that death occurred at <u>11:30 AM</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS (Street, city, town, state)		DATE SIGNED			
<u>A Paige Strong</u>		<u>M. D. Grant St, Salisbury Pa.</u>		<u>8/22/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>8/22/55</u>		<u>Grantsville</u>		<u>Grantsville, Garrett Co. Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8/22/55</u>		<u>Ethel Broadwater</u>		<u>Donald G. Newman</u>		<u>Grantsville, Md.</u>	



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## INSTRUCTIONS

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**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07768

7763

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Garrett</b>		STATE <b>W. Va.</b>		COUNTY <b>Milneral</b>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Mt. Lake Park</b>		<b>7 Wks.</b>		TOWN <b>Rural Keyser</b>		<b>85X-3</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Kiser Nursing Home</b>				STREET ADDRESS (If rural give location) <b>Route No 2</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>Louise W. Blauch</b>				<b>Aug. 1, 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Female</b>	<b>White</b>	<b>Married</b>	<b>May 11, 1876</b>	<b>79</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>House Wife</b>		<b>Own Home</b>		<b>Maryland</b>		<b>U. S. A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>George Leibrant</b>				<b>Ekizabeth Reib</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>no</b>		<b>----</b>		<b>Mrs. Mary Kiser Mt. Lake Park, Md</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422.1 IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>Antecedent Cause(S) DUE TO</b>						<b>2 days</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)</b>						<b>Arteriosclerotic Cardiovascular Disease</b>	
<b>(C)</b>						<b>years</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>also Myocarditis</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES <input type="checkbox"/> NO <input type="checkbox"/></b>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 8/1/55, 19, to 8/1/55, 19, that I last saw the deceased alive on 8/1/55, 19, and that death occurred at 4:10 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>Thomas L. Lusk</b>				<b>Oakland, Md.</b>		<b>8/1/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>8/4/1955</b>		<b>Burial Park Hillcrest Cemetery</b>		<b>Cumberland, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>8/2/55</b>		<b>Julia C. Rowan</b>		<b>Herbert C. Leighton</b>		<b>Oakland, Md.</b>	

107708

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 12

# CERTIFICATE OF DEATH

1. PLACE OF DEATH

Home

2. SEX

Male

3. RACE

White

4. AGE

5. DATE OF DEATH

6. TIME OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF BIRTH

10. OCCUPATION

11. MARITAL STATUS

12. PREVIOUS ILLNESS

13. MEDICAL HISTORY

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF WITNESSES

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF DEATH CERTIFICATE

18. SIGNATURE OF DEATH CERTIFICATE

19. SIGNATURE OF DEATH CERTIFICATE

BUREAU V. 3

AUG 9 1955

RECEIVED

4:10 P

2/1/55

2/1/55

2/1/55

2/1/55

RECEIVED

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## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07769

7764

## CERTIFICATE OF DEATH

Reg. Dist. No. 162

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> TOWN <u>Rural Grantsville</u>		<u>Life</u>		TOWN <u>Rural Grantsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>PETER</u> (Middle) <u>---</u> (Last) <u>BROADWATER</u>				(Month) <u>Aug.</u> (Day) <u>30</u> (Year) <u>19 55</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 12, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired Farmer</u>			<u>Own farm</u>	<u>New Germany, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Broadwater</u>				<u>Mary Custer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<u>none</u>		<u>Mrs. Media Broadwater, Avilton, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
177X IMMEDIATE CAUSE (A) <u>Calcetia</u>						<u>3 months</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>cancer of prostate</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>/</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<u>1953</u>		<u>advanced cancer of prostate</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-4-</u> , 19 <u>55</u> , to <u>8-30-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8-20-</u> , 19 <u>55</u> , and that death occurred at <u>5:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>L. M. King</u>				DATE SIGNED <u>9-3-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>9/1/55</u>		<u>St. Ann's</u>		<u>Avilton Garrett Co., Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>8-31-55</u>		<u>E. H. Broadwater</u>		<u>Donald J. Newman</u>		<u>Grantsville, Md.</u>	

TO WHOM IT MAY CONCERN: I hereby certify that the within and foregoing is a true and correct copy of the original as the same appears in the records of the County of [ ] State of [ ] this [ ] day of [ ] 19[ ] at [ ]

BUREAU V. S.

RECEIVED

1

## INSTRUCTIONS

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VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

077770

7765

## CERTIFICATE OF DEATH

Reg. Dist. No. 166

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>GARRETT</b>		STATE <b>MD</b> COUNTY <b>GARRETT</b>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY OR TOWN <b>CRELLIN MD</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		STREET ADDRESS		(If rural give location)	
TOWN <b>CRELLIN</b>							
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00</b>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>MARY L FRIEND</b>				<b>AUG 16 1955</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>FEMALE</b>	<b>WHITE</b>	<b>WIDOWED</b>	<b>SEPT. 10-1895</b>	<b>79</b>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>HOUSEWIFE</b>					<b>SWANTON MD</b>		<b>U.S.</b>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>MARCELLUS SMITH</b>				<b>SARAH BRAY.</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<b>GEORGE FRIEND CRELLIN MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422.1 IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>Chronic Heart Failure</b>						<b>2-3 yrs.</b>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>						<b>years</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>Art. C. V. D.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>Senility &amp; Degeneration</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 6 Nov 1948, to 8/16/55, that I last saw the deceased alive on 3/11/55, and that death occurred at 7:30 P.M. from the causes and on the date, stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>Thomas J. Rusty M.D.</b>				<b>Oakland MD</b>		<b>8/17/55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>BURIAL</b>		<b>AUG-19-1955</b>		<b>UNDERWOOD CEMETERY</b>		<b>NEAR OAKLAND MD.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<b>8/19/55</b>		<b>Julius A. Rowan R.R.</b>		<b>Emory Bolden</b>		<b>OAKLAND MD.</b>	

ГЛАВА 3

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William

ТОВАР

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John A. Egan

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CPH-01-7932

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23. 4. 2004

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Q M

ЗАРЯН ВЯЧ

MARCH 20 1952

George Friend  
Cypress Mill

BUREAU V. 5

AUG 26 1955

RECEIVED

РАДИИ ИСТИММО БОЗИРАСОН 144-71-04А

1917

3000-10000

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07771

7765

## CERTIFICATE OF DEATH

Film G 186, 9-22-55 Item 2 bh

Reg. Dist. No. 166

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Garrett</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mt. Lake Park, Bayard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Oakland</u>		LENGTH OF STAY (in this place) <u>2 days</u>		STREET ADDRESS (If rural give location) <u>11st/Not State/None</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Garrett County Memorial Hospital</u>							
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Henry</u> <u>JOHN</u> <u>Gay</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>August 13,</u> <u>1955</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widower</u>	<b>8. DATE OF BIRTH</b> <u>APRIL 5, 1884</u>	<b>9. AGE last birthday</b> <u>71</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>GAY, JOHN</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>DAWSON, SARAH</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Sam Gay, Bayard, W. Va.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>Acute Myocardial Infarction</u>						<u>48 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Sclerotic Heart Disease &amp; Coronary</u>						<u>6 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Hypertension</u>						<u>7 yrs</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>1849</u> <u>Aug 13</u> , 19 <u>55</u> , <u>7:42 A.M.</u> <b>to</b> <u>Aug 13</u> , 19 <u>55</u> , <b>that I last saw the deceased</b> <u>alive on</u> <u>Aug 12</u> , 19 <u>55</u> , <b>and that death occurred at</b> <u>7:42 A.M.</u> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>James H. Feaster, Jr.</u> <b>M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <u>Oakland, Md.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>8/15/55</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>BAYARD CEMETERY</u>		<b>LOCATION (City, town, or county) (State)</b> <u>BAYARD W. VA.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>3/14/55</u>		<u>Julia G. Rowan</u>		<u>Emory Bolden</u>		<u>Oakland Md</u>	

BUREAU V. S.

AUG 18 1955

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07772

## 7767 CERTIFICATE OF DEATH

Reg. Dist. No. 166

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>GARRETT</u>		STATE <u>MARYLAND</u>		COUNTY <u>GARRETT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>OAKLAND</u>		<u>10 Hrs. 57 M</u>		TOWN <u>OAKLAND</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>70</u> <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				<u>44</u> <u>PENNINGTON STREET</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>OLIN</u> <u>WALTER</u> <u>HARDESTY</u>				<u>8</u> <u>30</u> <u>19 55</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>MALE</u>	<u>WHITE</u>	<u>DIVORCED</u>	<u>7-4-1905</u>	<u>50</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>BARBER</u>				<u>MARYLAND</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>WALTER HARDESTY</u>				<u>ANNA C. SOWERS</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
(If Yes, give war or dates of service)		<u>217-20-7010</u>		<u>OAKLAND, MD.</u> <u>ANNA HARDESTY, 44 PENNINGTON ST.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>581.0</u> IMMEDIATE CAUSE (A) <u>Hemorrhage from esophageal varices</u>						<u>4 wks.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cirrhosis of liver</u>						<u>Unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M. A. P. M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <u>Aug 4</u> , 19 <u>55</u> , to <u>Aug 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Aug 29</u> , 19 <u>55</u> , and that death occurred at <u>3:45 AM</u> , from the causes and on the date stated above.		<b>SIGNATURE</b> <u>Joseph Alvarez</u> M.D.		<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b> <u>8th &amp; High St. Oakland, Md. Aug 31</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION</b> (City, town, or county) (State)	
<u>Burial</u>		<u>9/2/55</u>		<u>Oakland Cemetery</u>		<u>Oakland, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>9/2/55</u>		<u>Julia A Rowan</u>		<u>Emory Bolden</u>		<u>Oakland, Md.</u>	

NOTIFICATION

1. Name of deceased  
2. Date of death  
3. Place of death  
4. Cause of death  
5. Age at death  
6. Sex  
7. Race  
8. Religion  
9. Marital status  
10. Occupation  
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996. Religion  
997. Marital status  
998. Occupation  
999. Education  
1000. Social Security Number

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

055

Form 10-1

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Age at death

6. Sex

7. Race

8. Religion

9. Marital status

10. Occupation

11. Education

12. Social Security Number

13. Date of birth

14. Place of birth

15. Date of death

16. Place of death

17. Cause of death

18. Age at death

19. Sex

20. Race

21. Religion

22. Marital status

23. Occupation

24. Education

25. Social Security Number

26. Date of birth

27. Place of birth

28. Date of death

29. Place of death

30. Cause of death

BUREAU V. S.

SEP 8 1955

RECEIVED

DEPARTMENT OF HEALTH  
BALTIMORE, MD.

Handwritten signature

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07773

166

7769

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>GARRETT</b>		STATE <b>MARYLAND</b>		COUNTY <b>GARRETT</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>OAKLAND</b>		<b>4 DAYS</b>		TOWN <b>CRELLIN</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>JOHN S. JONES</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>AUGUST 16 19 55</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>WIDOWED</b>	<b>8. DATE OF BIRTH</b> <b>NOVEMBER 13, 1895</b>		<b>9. AGE last birthday</b> <b>59</b> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>OWNER &amp; OPERATOR OF ANTIQUE SHOP</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>WEST VIRGINIA</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S.</b>
<b>13. FATHER'S NAME</b> <b>William King Jones</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Wiles, LUCINDIA</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>219-14-6817</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>JOHN JONES - Silver Spring - Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
825x IMMEDIATE CAUSE (A) <b>Rupture of liver, spleen, and left kidney</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Kidney</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C) <b>UNDERLYING CAUSE LAST.</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH</b>							
<b>19a. DATE OF OPERATION</b> <b>Aug 12, 55</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Rupture of liver, spleen, &amp; left kidney</b>				<b>20. AUTOPSY?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, or INJURY street, office bldg, etc.)</b> <b>Highway</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State) <b>Garrett Md</b>			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>Aug 12, 55</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <b>Auto accident</b>			
<b>22. I hereby certify</b> that I attended the deceased from <b>Aug 12</b> , 19 <b>55</b> , to <b>Aug 16</b> , 19 <b>55</b> , that I last saw the deceased alive on <b>Aug 16</b> , 19 <b>55</b> , and that death occurred at <b>11:05 A.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>Joseph Alvarez M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <b>101 Third St, Oakland, Md.</b>		<b>DATE SIGNED</b> <b>Aug 18, 55</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Aug 19-1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Oakland</b>		<b>LOCATION (City, town, or county)</b> (State) <b>Md</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>8/19/55</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Julia G Rowan L.R.</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Emory Bolden</b>		<b>ADDRESS</b> <b>Oakland Md</b>	

# 7753 CERTIFICATE OF DEATH

Form No. 10

ALL DEATHS MUST BE REPORTED TO THE HEALTH DEPARTMENT

NAME OF DECEASED: **JOHN J. BROWN**  
AGE: **45**  
SEX: **M**  
RACE: **W**  
DATE OF BIRTH: **1910**  
PLACE OF BIRTH: **MD**  
MARRIED: **Y**  
OCCUPATION: **DRIVER**

DECEASED AT: **HOME**  
DATE OF DEATH: **1955**  
PLACE OF DEATH: **MD**  
CAUSE OF DEATH: **HEART DISEASE**  
MANNER OF DEATH: **NATURAL**

REPORTED BY: **DR. J. B. SMITH**  
DATE OF REPORT: **1955**  
PLACE OF REPORT: **MD**  
SIGNATURE OF REPORTER: **J. B. SMITH**

DECEASED'S SIGNATURE: *[Signature]*  
WITNESSES' SIGNATURES: *[Signatures]*

DECEASED'S ADDRESS: **1234 E. MAIN ST., BALTIMORE, MD.**  
DECEASED'S PHONE: **555-1234**  
DECEASED'S RELATIVES: **JOHN J. BROWN, JR., 5678 N. BROAD ST., BALTIMORE, MD.**

BUREAU V. S.

AUG 26 1955

RECEIVED

ENCLOSURE

NOTICE: This certificate is required by law to be filed with the health department within a certain time after death. It is also required to be filed with the local health officer. The health officer will issue a burial permit only after the certificate has been filed. The certificate is also required to be filed with the local health officer. The health officer will issue a burial permit only after the certificate has been filed. The certificate is also required to be filed with the local health officer. The health officer will issue a burial permit only after the certificate has been filed.

7769

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

07774 Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. ....

## 1. PLACE OF DEATH:

COUNTY GARRETT MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) LENGTH OF STAY (in this place)  
 TOWN RURAL CRELLIN  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY GARRETT  
 CITY (If outside corporate limits write RURAL and give nearest town) OR  
 TOWN RURAL CRELLIN MD  
 STREET ADDRESS (If rural, give location)

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
 (Type or Print) WILLIAM HENRY KISNER

4. DATE OF DEATH (Month) (Day) (Year)  
AUGUST 3 1955

## 5. SEX:

MALE

## 6. COLOR OR RACE:

WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

## 8. DATE OF BIRTH:

OCT. 29, 1876

## 9. AGE last birthday:

78 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): MINER

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): CRELLIN MD

12. CITIZEN OF WHAT COUNTRY? U.S.

## 13. FATHER'S NAME:

SONOTHAN KISNER

## 14. MOTHER'S MAIDEN NAME:

LUEVIZA HUFFMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

213-01-5113A

## 17. INFORMANT &amp; ADDRESS:

HARRY KISNER CRELLIN MD.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.1  
 Immediate cause

(a) CORONARY OCCLUSION  
 DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO  
 (c)

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

## SIGNATURE

E. J. Baumgartner

CHIEF MEDICAL EXAMINER

DEPUTY MEDICAL EXAMINER

M. D. ASSISTANT MEDICAL EXAM. 8/5/55

## 23. BURIAL, CREMATION, REMOVAL (Specify):

BURIAL

## DATE THEREOF

AUG-6-1955

## NAME OF CEMETERY OR CREMATORY

KISNER CEMETERY

## LOCATION (City, town, or county)

NEAR CRELLIN MD

DATE RECD BY LOCAL REG

REGISTRAR'S SIGNATURE

Julia A. Rowan

24. FUNERAL DIRECTOR

Emory Bolden

ADDRESS

OAKLAND MD

MARGIN RESERVED FOR BINDING

VS. A15A - 5 - 53

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1965

BUREAU V. S.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

7770

## CERTIFICATE OF DEATH

07775

Reg. Dist. No. 166

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Penna.</u>		COUNTY <u>Fayette</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Oakland</u>		LENGTH OF STAY (in this place) <u>419 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Markleysburg</u>		<u>75X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cuppett Nursing Home</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>EFFIE BELLE LARAWAY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Aug. 18, 1955.</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Aug. 12, 1880.</u>		<b>9. AGE last birthday</b> <u>75</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>0</u> Yrs. <u>6</u>	<b>IF UNDER 24 HRS.</b> Hours <u>0</u> Min. <u>0</u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Terra Alta, West Virginia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Clark May</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sidney Albright</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs. Alonzo Friend, Morgantown, W. Va.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>422.1 IMMEDIATE CAUSE (A)</b> <u>Longestive Heart Failure</u>				<u>Art. C.V. D.</u>		<u>2 mos.</u>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>				<b>(B)</b>		<u>years</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b>				<b>(C)</b>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>Senility</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <u>6-15</u> <u>54</u> to <u>8/18</u> , 19 <u>55</u>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>6-15</u> , 19 <u>54</u> , to <u>8/18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>8/15</u> , 19 <u>55</u> , and that death occurred at <u>2:05 PM</u> from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>Thomas F. Lusby</u>				<b>ADDRESS</b> (Street, city, town, state) <u>W.D. 5th &amp; Oak Streets, Oakland, Maryland.</u>		<b>DATE SIGNED</b> <u>8/19/55</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Removal &amp; Burial</u>		<b>DATE THEREOF</b> <u>Aug. 20, 1955.</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Terra Alta Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Terra Alta, W. Va.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>8/19/55</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Julia A. Henry</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>P. R. WATSON</u> <b>ADDRESS</b> <u>Terra Alta, W. Va.</u>			

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BUREAU V. S.

Aug 26 1955

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed in 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

07776

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Reg. Dist. No. ....

7771

## CERTIFICATE OF DEATH

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Oakland</u>		<u>27 day</u>		TOWN <u>Rural Grantsville</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Evans Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>JAMES FRANCIS MCKENZIE</u>				<u>Aug 14 1955</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 22, 1867</u>	<u>87</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Farming</u>		<u>Own farm</u>		<u>Avilton, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isadore McKenzie</u>				<u>Henrietta Garlitz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>none</u>		<u>none</u>		<u>Star Route Mrs. Elbert Garlitz, Frostburg, Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Cardio-renal-vascular Disease</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterioeclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 13 1955</u> to <u>August 14 1955</u> , that I last saw the deceased alive on <u>August 13 1955</u> , and that death occurred at <u>5:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>James C. Bowman</u>		M.D. <u>Donald J. Newman</u>		ADDRESS (Street, city, town, state) <u>Avilton, Garrett Co., Md</u>		DATE SIGNED <u>8/15/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>8/16/55</u>		<u>St Ann's</u>		<u>Avilton, Garrett Co., Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>8/15/1955</u>		<u>James C. Bowman</u>		<u>Donald J. Newman</u>		<u>Grantsville, Md</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

003330

Reg. Date: Jan. 1965

1. NAME OF DECEASED (Print or Type)

2. SEX

3. PLACE OF DEATH

4. DATE OF DEATH

5. TIME OF DEATH

6. PLACE OF BIRTH

7. AGE

8. OCCUPATION

9. MARITAL STATUS

10. CAUSE OF DEATH

11. MEDICAL OPINION

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF REGISTRAR

14. SIGNATURE OF WITNESSES

15. SIGNATURE OF FUNERAL HOME

16. SIGNATURE OF OTHER

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AUG 18 1965

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*Handwritten signature and date: 8/12/1965*

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INSTRUCTIONS

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**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

7772 **CERTIFICATE OF DEATH**

Reg. Dist. No. 07777 166

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>GARRETT.</b>		MARYLAND		STATE <b>M.D.</b>		COUNTY <b>GARRETT.</b>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <b>X TOWN CRELLIN</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL end give nearest town) <b>X TOWN CRELLIN.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>60</b>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>JOHN ROSCOE SMITH.</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>AUG. 28 1955.</b>			
<b>5. SEX</b> <b>MALE</b>	<b>6. COLOR OR RACE</b> <b>WHITE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>WIDOWED</b>	<b>8. DATE OF BIRTH</b> <b>APRIL-15-1879</b>	<b>9. AGE last birthday</b> <b>76.</b> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	<b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>MINER.</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>MEHOOPANY PA.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.</b>	
<b>13. FATHER'S NAME</b> <b>STEPHEN SMITH.</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>ELNORA WANDELL.</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>213-10-3739.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>MILDRED SMITH. CRELLIN MD.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>422.2 IMMEDIATE CAUSE (A)</b> <b>CHRONIC MYOCARDITIS</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (B)							
<b>STATING UNDERLYING CAUSE LAST. DUE TO</b> (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from April, 1955, to August, 1955, that I last saw the deceased alive on August, 1955, and that death occurred at 10:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Chambers</i>				<b>DATE SIGNED</b> <i>8/29/55</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>BURIAL</b>		<b>DATE THEREOF</b> <b>AUG-31-1955</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>TERRA ALTA CEMETERY</b>		<b>LOCATION (City, town, or county) (State)</b> <b>TERRA ALTA W. VA.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>DATE</b> <b>8/31/55</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Julia Rowan</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Emory Boldix</i>		<b>ADDRESS</b> <b>OAKLAND MD.</b>	

CERTIFICATE OF DEATH

GARRETT

CRELLIN

MD.

CRELLIN

GARRETT

JOHN

ROSCOE

SMITH

MALE WHITE

WEDNESDAY APRIL 12-1911

MINER

MENOMONY PA

STEPHEN SMITH

ELNORA WANDERL

213-10-333D. WEDNESDAY SMITH. CRELLIN MD.

BUREAU V. 2

SEP 8 1955

RECEIVED

10-30-55

BURIAL AUG 21-1955 TERRA ALTA CEMETERY TERRA ALTA W. VA.  
J. J. [Signature] [Signature] [Signature]